		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011544

Facility Name: Meadows Mennonite Home

Address: Rural Route # 1 (Number) Chenoa (City) 61726 (Zip Code)

County: McLean

Telephone Number: (309) 747-2702 **Fax #** (309) 747-2944

IDPA ID Number: 370791831001

Date of Initial License for Current Owners: 1958

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Mike Kaplan **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	22	Skilled (SNF)	22	8,052	1
2		Skilled Pediatric (SNF/PED)			2
3	108	Intermediate (ICF)	108	39,528	3
4		Intermediate/DD			4
5	29	Sheltered Care (SC)	29	10,614	5
6		ICF/DD 16 or Less			6
7	159	TOTALS	159	58,194	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,763	6,159		7,922	8
9	SNF/PED					9
10	ICF	11,801	24,717		36,518	10
11	ICF/DD					11
12	SC		3,351		3,351	12
13	DD 16 OR LESS					13
14	TOTALS	13,564	34,227		47,791	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.12%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	276,168	14,880	3,818	294,866		294,866		294,866			1
2	Food Purchase		285,864		285,864		285,864		285,864			2
3	Housekeeping	171,904	29,249	1,578	202,731		202,731		202,731			3
4	Laundry	59,840	13,970	21,582	95,392		95,392		95,392			4
5	Heat and Other Utilities			164,905	164,905		164,905		164,905			5
6	Maintenance	87,210	18,710	89,781	195,701		195,701		195,701			6
7	Other (specify):*											7
8	**TOTAL General Services**	595,122	362,673	281,664	1,239,459		1,239,459		1,239,459			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	1,803,714	128,008	259,119	2,190,841		2,190,841		2,190,841			10
10a	Therapy			11,318	11,318		11,318		11,318			10a
11	Activities	100,725	4,992	2,454	108,171		108,171	(3,032)	105,139			11
12	Social Services	93,244	492	255	93,991		93,991		93,991			12
13	Nurse Aide Training	5,320		2,002	7,322		7,322		7,322			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,003,003	133,492	279,948	2,416,443		2,416,443	(3,032)	2,413,411			16
	C. General Administration											
17	Administrative	121,674			121,674		121,674		121,674			17
18	Directors Fees											18
19	Professional Services			29,020	29,020		29,020	(1,100)	27,920			19
20	Dues, Fees, Subscriptions & Promotions			38,202	38,202		38,202		38,202			20
21	Clerical & General Office Expenses	189,842	11,431	42,793	244,066		244,066	(6,100)	237,966			21
22	Employee Benefits & Payroll Taxes			625,508	625,508		625,508		625,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,881	20,881		20,881	(4,805)	16,076			24
25	Other Admin. Staff Transportation			5,018	5,018		5,018		5,018			25
26	Insurance-Prop.Liab.Malpractice			26,389	26,389		26,389		26,389			26
27	Other (specify):*											27
28	**TOTAL General Administration**	311,516	11,431	787,811	1,110,758		1,110,758	(12,005)	1,098,753			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,909,641	507,596	1,349,423	4,766,660		4,766,660	(15,037)	4,751,623			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Meadows Mennonite Home #0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			357,530	357,530		357,530		357,530			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,562	155,562		155,562	(52,571)	102,991			32
33	Real Estate Taxes			30,701	30,701		30,701	(30,701)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			649	649		649		649			35
36	Other (specify):*											36
37	**TOTAL Ownership**			544,442	544,442		544,442	(83,272)	461,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,370	71,370		71,370		71,370			42
43	Other (specify):* **Nonallowable costs**	130,278	1,986	168,404	300,668		300,668	(300,668)				43
44	**TOTAL Special Cost Centers**	130,278	1,986	239,774	372,038		372,038	(300,668)	71,370			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,039,919	509,582	2,133,639	5,683,140		5,683,140	(398,977)	5,284,163			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(48,071)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,500)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,100)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5a attached	(345,306)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (398,977)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	-		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (398,977)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Meadows Mennonite Home

ID# 0011544

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Meadows Mennonite Retirement Home	Meadows	Independent Living Housing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		x	Mortgage	$8,319.00	6/1976	$ 1,620,000	$ 885,744	6/2016	0.0500	$ 45,573	1
2	FMHA		x	Mortgage	$9,876.00	2/1996	1,782,500	1,692,667	3/2028	0.0500	85,371	2
3	Heartland Bank		x	Mortgage	$13,871.00	1/1996	1,500,000	17,744	2/2002	0.0875	10,098	3
4	Newcourt Leasing		x	Copier	$220.00	5/97	8,000	1,333	6/30/01	0.2000	483	4
5	See Schedule 9A				$1,965.00		108,201	64,006			5,470	5
	Working Capital											
6	Bank of Chenoa		x	Line of Credit		6/30/00	200,000	135,000	06/30/01	0.0950	1,401	6
7												7
8												8
9	TOTAL Facility Related				$34,251.00		$ 5,218,701	$ 2,796,494			$ 148,396	9
	B. Non-Facility Related*											
10	Bank of Chenoa		x	Bus Loan	$682.00	11/1999	34,000	17,600	11/2004	0.0753	2,166	10
11												11
12	See Schedule 9A										(47,571)	12
13												13
14	TOTAL Non-Facility Related				$682.00		$ 34,000	$ 17,600			$ (45,405)	14
15	TOTALS (line 9+line14)						$ 5,252,701	$ 2,814,094			$ 102,991	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home **#** 0011544 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 76,955 B. General Construction Type: Exterior Masonry Frame Wood, Brick, Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Meadows Mennonite Retirement Home Independent Living Housing

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	683,400	1920	$ 15,065	1
2	Facility		1950	27,033	2
3	TOTALS	683,400		$ 42,098	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1923	1923	$ 74,144	$		$	$	$	4
5	23		1952	1952	86,314						5
6	25		1966	1966	225,617						6
7	94		1978	1978	2,348,846						7
8	17		1997	1997	3,898,885						8
	Improvement Type**										
9	Various Building Improvements			1979	119,175						9
10	Various Building Improvements			1980	17,129						10
11	Various Building Improvements			1981	13,566						11
12	Various Building Improvements			1982	1,645						12
13	Various Building Improvements			1983	217,187						13
14	Various Building Improvements			1984	6,839						14
15	Various Building Improvements			1985	31,287						15
16	Various Building Improvements			1986	14,477						16
17	Various Building Improvements			1987	15,979						17
18	Various Building Improvements			1988	8,451						18
19	Various Building Improvements			1989	24,261		NOTE : DETAIL UNAVAILABLE				19
20	Various Building Improvements			1990	5,948						20
21	Various Building Improvements			1991	10,093						21
22	Various Building Improvements			1992	42,794						22
23	Various Building Improvements			1993	28,059						23
24	Various Building Improvements			1994	94,725						24
25	Various Building Improvements			1995	48,021						25
26	Engineering Cad & Survey			1996	675						26
27	Excavating			1996	2,000						27
28	Boiler Repair - Cleveland			1996	503						28
29	Roof A/C Repair			1996	718						29
30	Window Coverings			1996	1,039						30
31	Sewage Pump Repairs			1996	1,685						31
32	Siding			1997	22						32
33	Siding			1997	245						33
34	Carpet			1997	1,090						34
35	Windows			1997	607						35
36	TOTAL (lines 4 thru 35)				$ 7,342,026	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2 Patios			1997	770						9
10	Landscaping			1997	957						10
11	Glass			1997	677						11
12	Service-Intercom System Repairs			1997	871						12
13	Fiber Optics - Computer Wiring			1997	2,887						13
14	Liquid Storage Cabinet Tank			1997	572						14
15	Paging System- Bennett			1997	2,288						15
16	Install Heating & Cooling			1997	15,161						16
17	Compressors			1997	692						17
18	Compressors			1997	961						18
19	Window Blinds			1997	1,539		NOTE : DETAIL UNAVAILABLE				19
20	Motor A/C Motor & Starter for 2 Ton Unit			1997	715						20
21	Repair Cool			1997	421						21
22	Repair Cool			1997	328						22
23	2 Roof top Units			1997	1,295						23
24	A/C Part Repairs			1997	733						24
25	Power Server			1997	150						25
26	Labor & Installation Units Rooftop A/C			1997	19,250						26
27	2 Carrier Heating & Cooling			1997	19,250						27
28	Intercom Wiring Repairs			1997	696						28
29	Carousel Tub			1997	12,423						29
30	Landscaping			1997	30,518						30
31	Curtains, Valances			1997	10,077						31
32	Patio Garden Landscaping			1997	12,842						32
33	Fence & Gate			1997	10,162						33
34	Telephone Wiring			1997	1,462						34
35	Draperies - Clark			1997	869						35
36	TOTAL (lines 4 thru 35)				$ 148,566	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ASI Sign System			1997	2,547						9
10	Rocks For 2 Courtyards			1998	2,070						10
11	Asphalt Maintenance			1998	5,500						11
12	Window Room # 51			1998	444						12
13	Magnetic Gate Contact			1998	228						13
14	Carpet Restroom			1998	330						14
15	Carpet 3 Rooms			1998	793						15
16	Maintenance Shop			1998	909						16
17	2 A/C Compressors			1998	1,006						17
18	Heat & Air Thermostat			1998	1,410						18
19	Natural Gas Steamer			1998	7,495		NOTE : DETAIL UNAVAILABLE				19
20	Heat Duct Repair			1998	761						20
21	Repair Engine & Generator			1998	1,322						21
22	Alarm System Phase 1			1998	44,529						22
23	Sewage Pump Rehab			1998	7,208						23
24	Water Tower Rehab			1998	63,699						24
25	OSHA Upgrades			1998	111						25
26	Required OSHA Items			1998	458						26
27	Eye Wash Station			1998	585						27
28	1 CS Spill Kits			1998	122						28
29	Repair Roadway			1999	3,500						29
30	Landscaping Improvements			1999	2,259						30
31	Station 1 Door Keypads			1999	1,442						31
32	Station 1 Code Alert System			1999	15,298						32
33	Station 1 Nurse Call System			1999	11,924						33
34	Ceiling Installation			1999	1,945						34
35	Improvements to Brown Shed			1999	1,288						35
36	TOTAL (lines 4 thru 35)				$ 179,183	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Safety Bars in Alzheimer's Unit			1999	2,350						9
10	Bronze Door & Closer			1999	1,806						10
11	Hardware for Existing Doors in Alzheimer's Unit			1999	5,536						11
12	Sensor Base for Alarm			1999	231						12
13	Repair Boiler Station 4			1999	1,140						13
14	Repair Generator			1999	3,067						14
15	Water Heater for Kitchen			1999	878						15
16	Panic Devices on Doors in Alzheimer Unit			1999	688						16
17	Alarm System			1999	7,562						17
18	Storage Cabinets & Installation			1999	5,242		NOTE : DETAIL UNAVAILABLE				18
19	Elevator Eye			1999	1,978						19
20	Fire Alarm System Materials & Labor			1999	27,650						20
21	Compressor for Freezer			1999	1,809						21
22	Sewer Improvements (Check Valves)			1999	1,312						22
23	New Pipes in Well			1999	921						23
24	New Alzheimer Unit Sign			1999	1,144						24
25	Station 4 Door Seal Parts & Labor			1999	1,163						25
26	Carpet - Station 5			2000	1,126						26
27	Station 5 Remodel			2000	320						27
28	Station 5 Tile			2000	530						28
29	Bathroom Fixtures - Station 5			2000	1,675						29
30	Garage Door Enlargement			2000	1,276						30
31	Elevator Cylinder			2000	16,746						31
32	Fire Alarm System			2000	18,000						32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 104,150	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Mastercare Hydrobath			2000	9,490						9
10	Door Locks on Soiled Linen Closet			2000	568						10
11	Air Conditioner Motor			2000	657						11
12	Air Conditioner Compressor			2000	1,732						12
13	Alarm System			2000	35,000						13
14	Alarm System			2000	18,000						14
15	Alarm System Sensor			2000	864						15
16	Premium Lawn			2000	755		NOTE : DETAIL UNAVAILABLE				16
17	Parking Lot Addition			2000	7,355						17
18	New Controller for Sewer			2000	1,573						18
19	Sewer Improvements			2000	752						19
20	Water Main Work			2000	2,203						20
21	Water Main Extension			2000	8,465						21
22	Chlorinator			2000	1,389						22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 88,803	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 650,775	$	$	$		$	37
38	Current Year Purchases	74,269						38
39	Fully Depreciated Assets	360,044	**					39
40								40
41	TOTALS	$ 1,085,088	$	$	$		$	41

** NOTE: DETAIL UNAVAILABLE

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,989,914	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Housing Units	$ 1,348,614	$	$	52
53	Residential Vehicles	91,992			53
54					54
55					55
56					56
57	TOTALS	$ 1,440,606	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 649 Description: Dishwasher
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,500	$	$ 1,500
2	Books and Supplies			202		202
3	Classroom Wages	(a)		5,320		5,320
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			300		300
9	TOTALS		$	$ 7,322	$	$ 7,322
10	SUM OF line 9, col. 1 and 2	(e)	$ 7,322			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 661,436	$ 661,436	1
2	Cash-Patient Deposits	15,184	15,184	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	301,431	301,431	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,965	11,965	6
7	Other Prepaid Expenses	21,088	21,088	7
8	Accounts Receivable (owners or related parties)	18,063	18,063	8
9	Other(specify): Show Bus Non-Patient Care	28,620	28,620	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,057,787	$ 1,057,787	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	628,897	628,897	12
13	Land	217,622	217,622	13
14	Buildings, at Historical Cost	8,671,461	8,671,461	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,387,492	1,387,492	16
17	Accumulated Depreciation (book methods)	(3,916,589)	(3,916,589)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): See Sch 17A	770,297	770,297	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,759,180	$ 7,759,180	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,816,967	$ 8,816,967	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,326	$ 70,326	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,709	16,709	28
29	Short-Term Notes Payable	351,392	212,606	29
30	Accrued Salaries Payable	123,161	123,161	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,700		32
33	Accrued Interest Payable	31,016	31,016	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17a	235,193	235,193	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 859,497	$ 689,011	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	677,644	40,012	39
40	Mortgage Payable	2,561,476	2,561,476	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,239,120	$ 2,601,488	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,098,617	$ 3,290,499	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,718,350	$ 5,526,468	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,816,967	$ 8,816,967	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,754,799	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,754,799	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(36,447)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (36,447)	17
	B. Transfers (Itemize):		
18	Rounding	(2)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,718,350	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,421,484	1
2	Discounts and Allowances for all Levels	(419,031)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,002,453	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,215	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 12,215	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,955	13
14	Non-Patient Meals	505	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	92,573	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 96,033	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	48,071	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,071	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	487,921	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 487,921	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,646,693	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,239,459	31
32	Health Care	2,416,443	32
33	General Administration	1,110,758	33
	B. Capital Expense		
34	Ownership	544,442	34
	C. Ancillary Expense		
35	Special Cost Centers	300,668	35
36	Provider Participation Fee	71,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,683,140	40
41	**Income before Income Taxes (line 30 minus line 40)****	(36,447)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (36,447)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,634	2,021	$ 44,763	$ 22.15	1
2	Assistant Director of Nursing	1,859	2,097	38,638	18.43	2
3	Registered Nurses	12,177	13,867	233,127	16.81	3
4	Licensed Practical Nurses	24,571	27,090	413,357	15.26	4
5	Nurse Aides & Orderlies	93,507	105,067	1,038,027	9.88	5
6	Nurse Aide Trainees	664	664	5,320	8.01	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,062	1,106	11,478	10.38	8
9	Activity Director	1,888	2,084	23,735	11.39	9
10	Activity Assistants	9,294	10,535	76,990	7.31	10
11	Social Service Workers	3,725	4,189	56,078	13.39	11
12	Dietician					12
13	Food Service Supervisor	2,944	3,213	37,730	11.74	13
14	Head Cook	7,517	8,370	70,879	8.47	14
15	Cook Helpers/Assistants	22,361	24,416	167,559	6.86	15
16	Dishwashers					16
17	Maintenance Workers	5,859	6,388	87,210	13.65	17
18	Housekeepers	21,573	24,153	171,904	7.12	18
19	Laundry	5,479	5,748	59,840	10.41	19
20	Administrator	1,902	2,172	52,934	24.37	20
21	Assistant Administrator					21
22	Other Administrative	1,461	1,644	68,740	41.81	22
23	Office Manager	3,022	3,220	91,372	28.38	23
24	Clerical	9,048	10,003	98,470	9.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify) Sch 20A	3,936	4,405	61,490	13.96	32
33	Other(specify) See Schedule 20A	9,943	10,693	130,278	12.18	33
34	TOTAL (lines 1 - 33)	245,426	273,145	$ 3,039,919 *	$ 11.13	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,800	L. 9 C. 3	36
37	Medical Records Consultant	Monthly	500	L. 10 C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L. 10 C. 3	39
40	Physical Therapy Consultant	Monthly	11,271	L. 10a C.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,525	L. 11 C. 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,696		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,594	$ 56,241	L. 10 C. 3	50
51	Licensed Practical Nurses	530	16,243	L. 10 C. 3	51
52	Nurse Aides	9,837	179,440	L. 10 C. 3	52
53	TOTAL (lines 50 - 52)	11,961	$ 251,924		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nancy Stedman	Administrator	0.00%	$ 52,934
Robert O. Bertsche	CEO	0.00%	68,740
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 121,674

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Dunbar Breitweiser	Accounting	$ 6,700
Frost Ruttenberg & Rothblatt, P.C.	Accounting	4,800
Health Outcomes Mgmt	Computer	12,176
Advanced Information Systems	Computer	2,980
Michael Stedman	Computer	1,264
Hartweg Mueller Turner	Legal	1,100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,020

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,437
Unemployment Compensation Insurance	
FICA Taxes	221,752
Employee Health Insurance	231,372
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403B Annuity	58,022
Group Life Insurance	3,851
Sick Pay	12,731
Employee Benefits Admin. Fee	3,212
Employee Relations	10,982
Bonuses	9,874
Counseling	4,275
TOTAL (agree to Schedule V, line 22, col.8)	$ 625,508

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	28,675
Health Care Worker Background Check	672
(Indicate # of checks performed 56)	
LSN	5,102
Mennonite Health Service	1,032
Miscellaneous Dues	2,589
Miscellaneous Subscriptions	132
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,202

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
See attached schedule	16,076
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,076

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Meadows Mennonite Home # 0011544 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadows Mennonite Home **#** 0011544 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $5,102**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,662** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **71,370**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Heinold-Banwart, Ltd.** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.